SECTION 5

COMPLETING FORMS

Forms

This section has been designed to assist Insurance Coordinators in the completion of Health Insurance Forms.

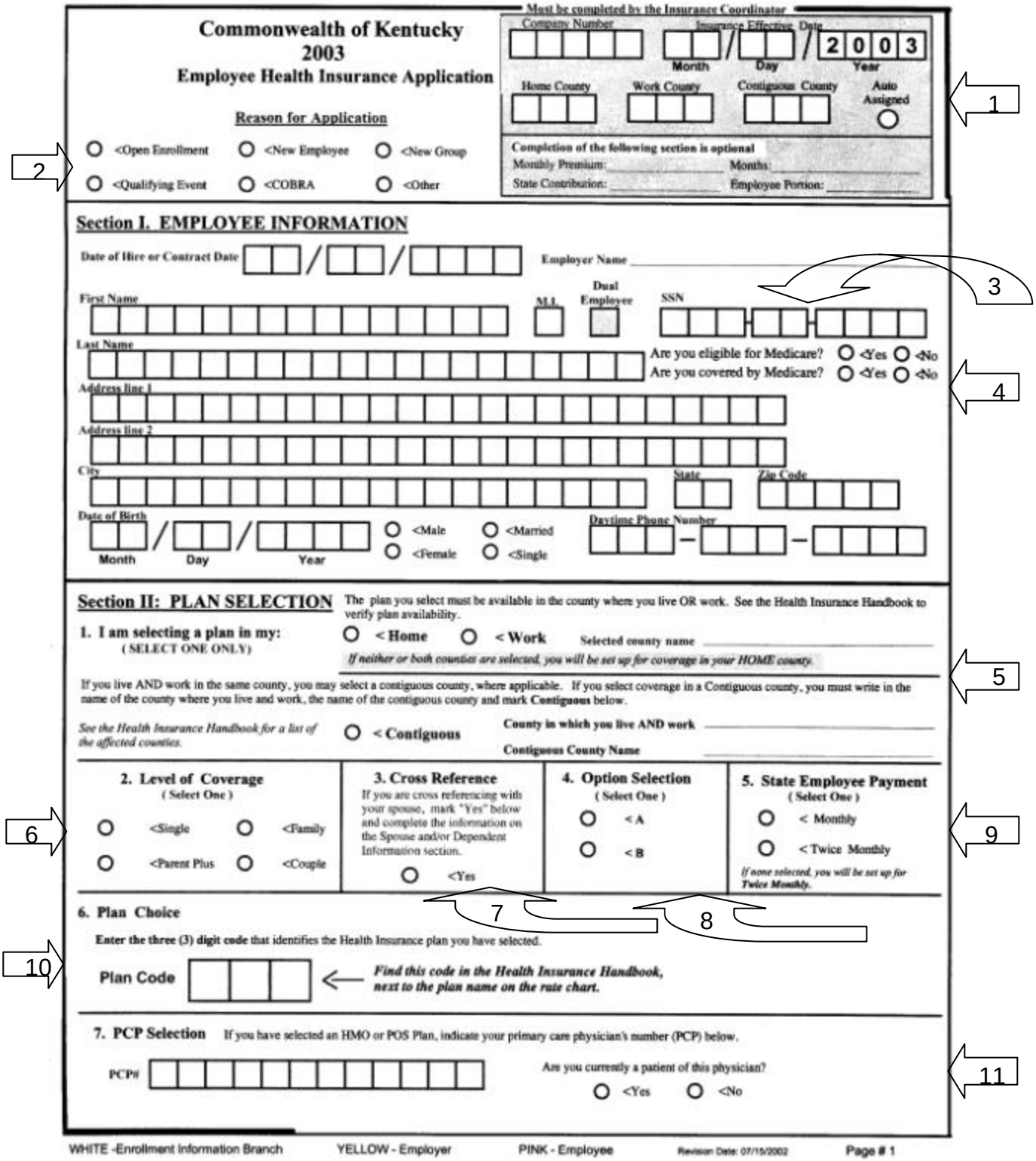
Insurance Coordinator's Responsibilities

1. Complete the shaded areas at the top of the application.
2. Verify the employee has completed all information.
3. Sign and date the last page of the application.
4. Mail the top copy of the completed application to the OPEHI's Enrollment Information Branch (contact information provided on page ii).
5. Keep the employer copy for your file. The employee copy should be given to the employee at the time of completion.

If you have questions regarding completion of these forms, contact OPEHI's Enrollment Information Branch.

If you need additional supplies, contact OPEHI's Member Services Branch.

Sample Health Insurance Application – Page 1



Must be completed by the Insurance Coordinator

Commonwealth of Kentucky
2003
Employee Health Insurance Application

Company Number | Insurance Effective Date: Month / Day / Year (2003)

Home County | Work County | Contiguous County | Auto Assigned

Reason for Application

<Open Enrollment <New Employee <New Group
<Qualifying Event <COBRA <Other

Completion of the following section is optional
Monthly Premium: Months:
State Contribution: Employee Portion:

Section I. EMPLOYEE INFORMATION

Date of Hire or Contract Date | Employer Name

First Name | M.I. | Dual Employee | SSN

Last Name

Are you eligible for Medicare? <Yes <No
Are you covered by Medicare? <Yes <No

Address line 1

Address line 2

City | State | Zip Code

Date of Birth (Month / Day / Year) <Male <Female <Married <Single

Daytime Phone Number

Section II: PLAN SELECTION

The plan you select must be available in the county where you live OR work. See the Health Insurance Handbook to verify plan availability.

1. I am selecting a plan in my: (SELECT ONE ONLY) < Home < Work

Selected county name

If neither or both counties are selected, you will be set up for coverage in your HOME county.

If you live AND work in the same county, you may select a contiguous county, where applicable. If you select coverage in a Contiguous county, you must write in the name of the county where you live and work, the name of the contiguous county and mark **Contiguous** below.

See the Health Insurance Handbook for a list of the affected counties.

< Contiguous

County in which you live AND work

Contiguous County Name

2. Level of Coverage (Select One)
<Single <Family
<Parent Plus <Couple

3. Cross Reference
If you are cross referencing with your spouse, mark "Yes" below and complete the information on the Spouse and/or Dependent Information section.
<Yes

4. Option Selection (Select One)
< A
< B

5. State Employee Payment (Select One)
< Monthly
< Twice Monthly
If none selected, you will be set up for Twice Monthly.

6. Plan Choice

Enter the three (3) digit code that identifies the Health Insurance plan you have selected.

Plan Code

Find this code in the Health Insurance Handbook, next to the plan name on the rate chart.

7. PCP Selection If you have selected an HMO or POS Plan, indicate your primary care physician's number (PCP) below.

PCP#

Are you currently a patient of this physician? <Yes <No

WHITE -Enrollment Information Branch YELLOW - Employer PINK - Employee Revision Date: 07/15/2002 Page # 1

1 2 3 4 5 6 7 8 9 10 11

Completing the Health Insurance Application – Page 1

For complete details on completing each section of the application, refer to the instruction sheet attached to the application.

1. The Insurance Coordinator must complete the shaded area of the application.

2. Indicate the reason for the application.

3. Ensure that the employee has entered the correct Social Security Number.

4. Verify that the employee has completed all demographic information.

5. An employee may only make one selection in this Section. He/she must select coverage in his/her home county, work county or, if applicable, a contiguous county. Refer to Section 1 for an explanation of contiguous county selection. If the employee selects coverage in a contiguous county, he/she must indicate the county in which he/she lives and works as well as the contiguous county name.

6. The employee must indicate level of coverage for which he/she is applying. Ensure that the level of coverage selected corresponds with the information listed on the dependent section of the application.

7. If both husband and wife are eligible for coverage in the Public Employee Health Insurance Program, they may cross-reference. Refer to Section 1 for requirements that must be met in order to qualify for cross-reference.

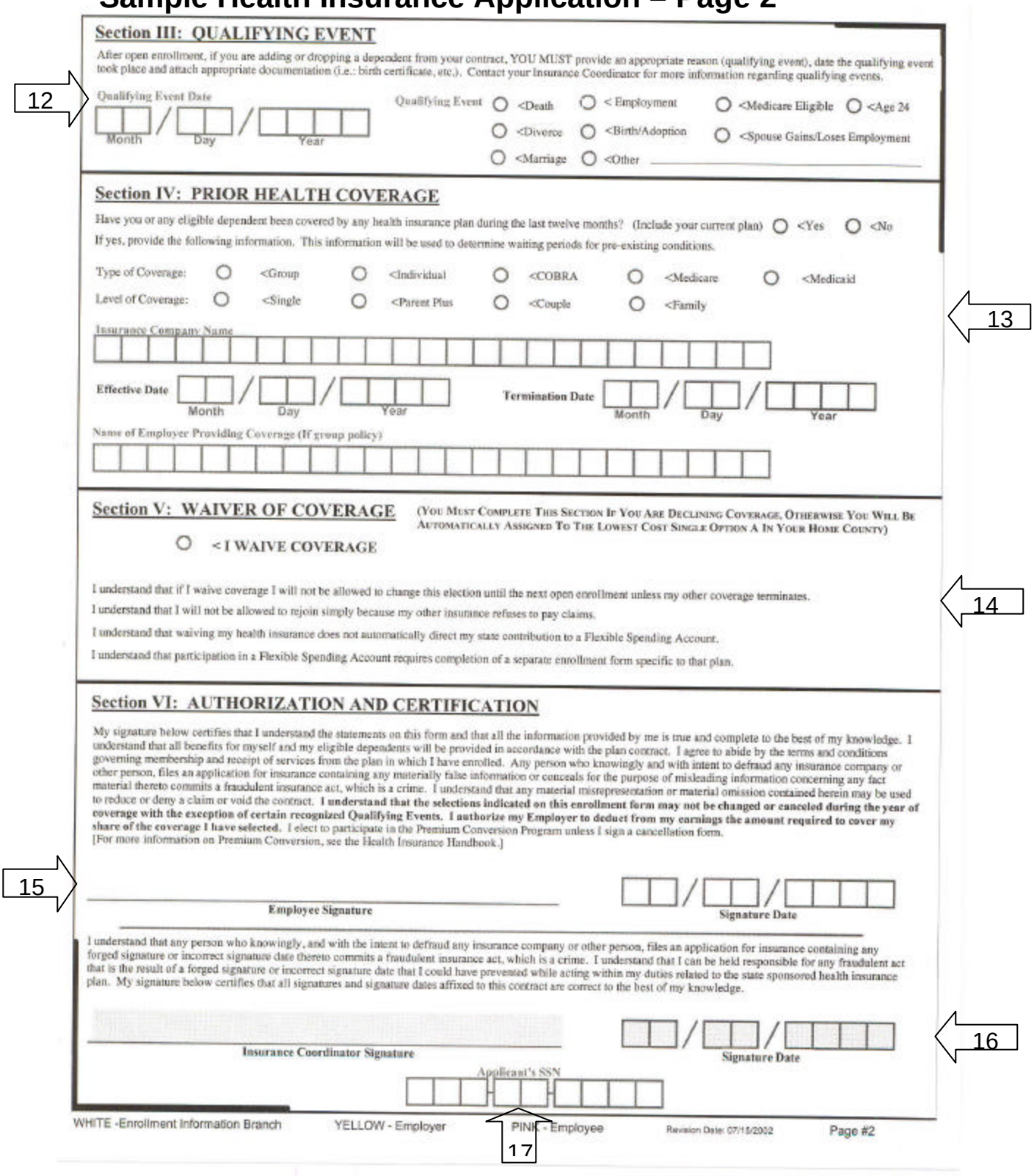
8. The employee must indicate coverage option.

9. The employee should indicate payment option. If no payment option is selected, the payment option will default to twice-monthly.

10. The plan code determines the health insurance carrier and the plan type (PPO/HMO/POS/EPO) selected by the employee. Verify that the employee enters a valid three-digit plan code. A complete list of plan codes is provided in the *Health Insurance Handbook*. Changes to a valid plan code will not be permitted beyond the appropriate deadlines.

11. If the employee selects a plan that requires utilization of a Primary Care Physician, employee must include the PCP number from the carrier's provider directory.

Sample Health Insurance Application – Page 2



Section III: QUALIFYING EVENT

After open enrollment, if you are adding or dropping a dependent from your contract, YOU MUST provide an appropriate reason (qualifying event), date the qualifying event took place and attach appropriate documentation (i.e.: birth certificate, etc.). Contact your Insurance Coordinator for more information regarding qualifying events.

12

Qualifying Event Date ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Qualifying Event ○ <Death ○ < Employment ○ <Medicare Eligible ○ <Age 24 ○ <Divorce ○ <Birth/Adoption ○ <Spouse Gains/Loses Employment ○ <Marriage ○ <Other _____

Section IV: PRIOR HEALTH COVERAGE

Have you or any eligible dependent been covered by any health insurance plan during the last twelve months? (Include your current plan) ○ <Yes ○ <No

If yes, provide the following information. This information will be used to determine waiting periods for pre-existing conditions.

Type of Coverage: ○ <Group ○ <Individual ○ <COBRA ○ <Medicare ○ <Medicaid

Level of Coverage: ○ <Single ○ <Parent Plus ○ <Couple ○ <Family

13

Insurance Company Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Effective Date ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year) **Termination Date** ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Name of Employer Providing Coverage (If group policy) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section V: WAIVER OF COVERAGE

(YOU MUST COMPLETE THIS SECTION IF YOU ARE DECLINING COVERAGE, OTHERWISE YOU WILL BE AUTOMATICALLY ASSIGNED TO THE LOWEST COST SINGLE OPTION A IN YOUR HOME COUNTY)

○ < I WAIVE COVERAGE

14

I understand that if I waive coverage I will not be allowed to change this election until the next open enrollment unless my other coverage terminates.

I understand that I will not be allowed to rejoin simply because my other insurance refuses to pay claims.

I understand that waiving my health insurance does not automatically direct my state contribution to a Flexible Spending Account.

I understand that participation in a Flexible Spending Account requires completion of a separate enrollment form specific to that plan.

Section VI: AUTHORIZATION AND CERTIFICATION

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan contract. I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to reduce or deny a claim or void the contract. **I understand that the selections indicated on this enrollment form may not be changed or canceled during the year of coverage with the exception of certain recognized Qualifying Events. I authorize my Employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.** I elect to participate in the Premium Conversion Program unless I sign a cancellation form.
[For more information on Premium Conversion, see the Health Insurance Handbook.]

15

Employee Signature ☐☐ / ☐☐ / ☐☐☐☐ **Signature Date**

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the state sponsored health insurance plan. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Insurance Coordinator Signature ☐☐ / ☐☐ / ☐☐☐☐ **Signature Date**

16

Applicant's SSN ☐☐☐-☐☐-☐☐☐☐

WHITE -Enrollment Information Branch YELLOW - Employer PINK - Employee Revision Date: 07/15/2002 Page #2

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Completing the Health Insurance Application – Page 2

12. If the employee is completing the application as a result of a Qualifying Event, he/she must indicate the type of Qualifying Event and enter the date of the event. Attach documentation to the application.

13. If an employee had prior health insurance coverage, he/she must indicate such coverage in this section.

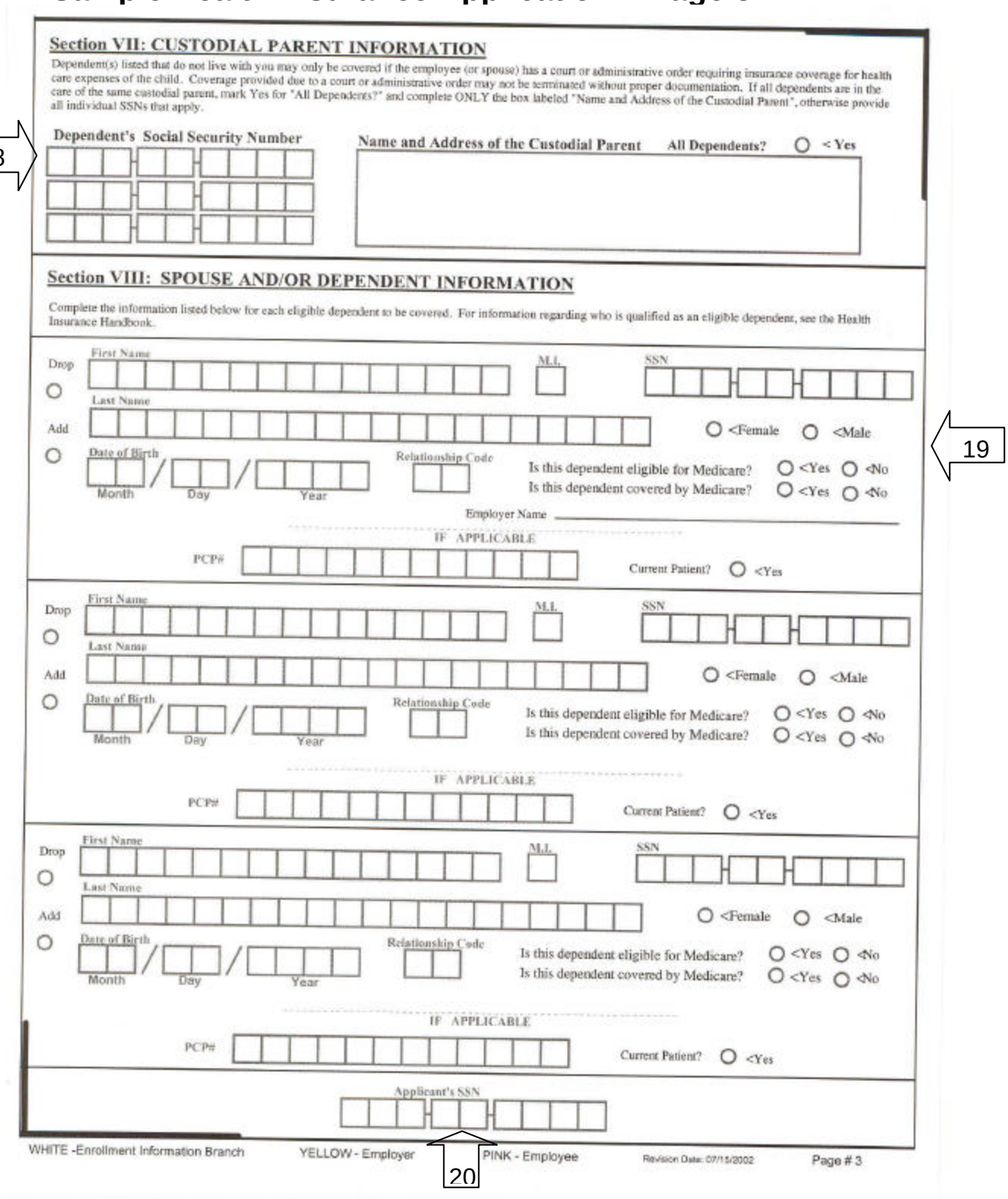
14. If an employee chooses to waive health insurance coverage, he/she must indicate that selection in this Section. If employee is eligible for a Flexible Spending Account and desires to direct the employer contribution to a Health Care Spending Account, he/she must complete the appropriate Flexible Spending Account application.

15. The employee must sign and date the application. An application will not be processed without this information.

16. The Insurance Coordinator must sign and date the application.

17. Ensure that the employee enters his/her correct Social Security Number.

Sample Health Insurance Application – Page 3



Section VII: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if the employee (or spouse) has a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation. If all dependents are in the care of the same custodial parent, mark Yes for "All Dependents?" and complete ONLY the box labeled "Name and Address of the Custodial Parent", otherwise provide all individual SSNs that apply.

18

Dependent's Social Security Number

Name and Address of the Custodial Parent

All Dependents? ○ <Yes

Section VIII: SPOUSE AND/OR DEPENDENT INFORMATION

Complete the information listed below for each eligible dependent to be covered. For information regarding who is qualified as an eligible dependent, see the Health Insurance Handbook.

Drop ○ Add ○ First Name M.I. SSN Last Name

○ <Female ○ <Male

Date of Birth Month / Day / Year

Relationship Code

Is this dependent eligible for Medicare? ○ <Yes ○ <No

Is this dependent covered by Medicare? ○ <Yes ○ <No

19

Employer Name

IF APPLICABLE

PCP# Current Patient? ○ <Yes

Drop ○ Add ○ First Name M.I. SSN Last Name

○ <Female ○ <Male

Date of Birth Month / Day / Year

Relationship Code

Is this dependent eligible for Medicare? ○ <Yes ○ <No

Is this dependent covered by Medicare? ○ <Yes ○ <No

IF APPLICABLE

PCP# Current Patient? ○ <Yes

Drop ○ Add ○ First Name M.I. SSN Last Name

○ <Female ○ <Male

Date of Birth Month / Day / Year

Relationship Code

Is this dependent eligible for Medicare? ○ <Yes ○ <No

Is this dependent covered by Medicare? ○ <Yes ○ <No

IF APPLICABLE

PCP# Current Patient? ○ <Yes

Applicant's SSN

WHITE -Enrollment Information Branch YELLOW - Employer PINK - Employee Revision Date: 07/15/2002 Page # 3

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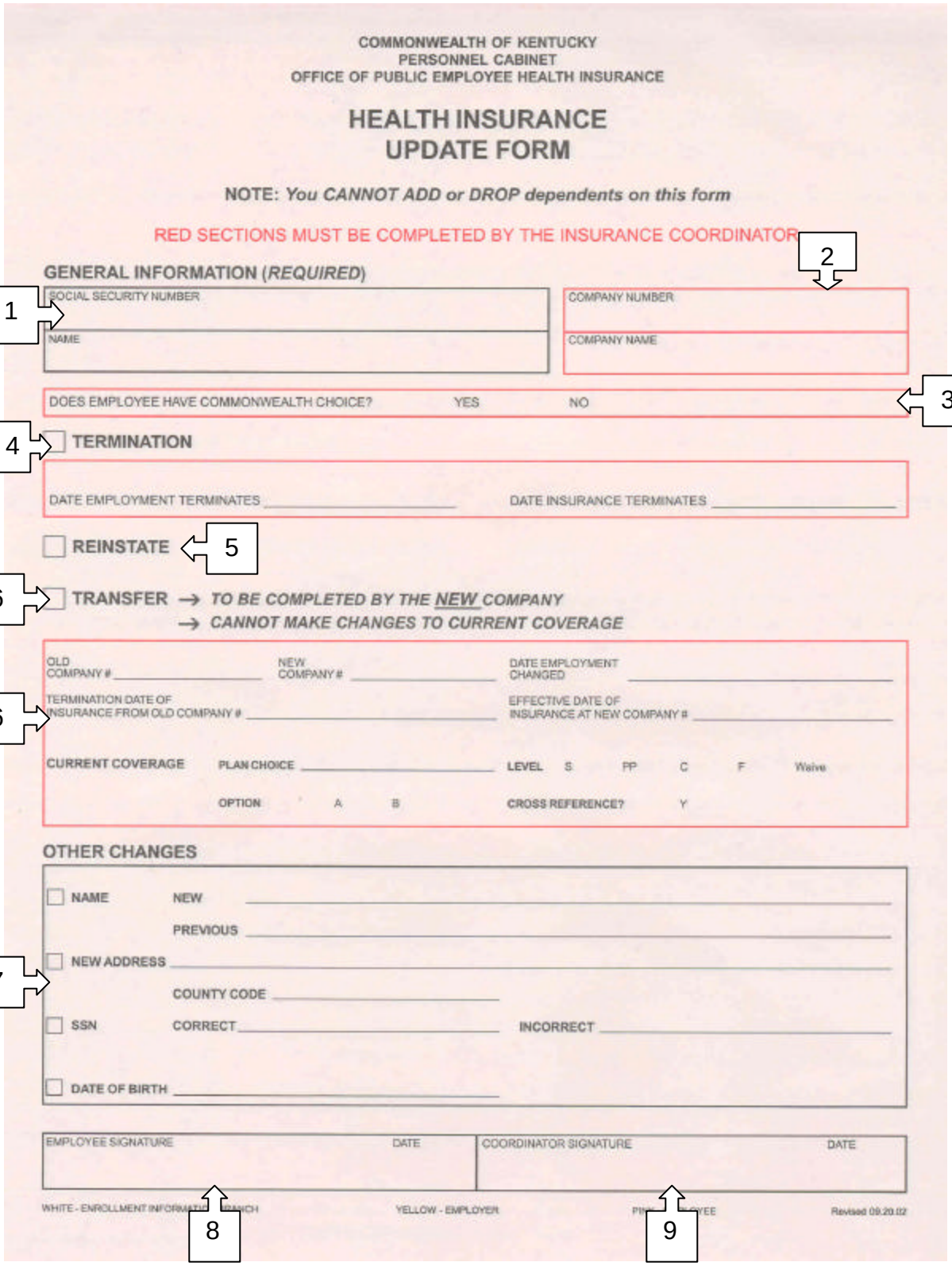
Completing the Health Insurance Application – Page 3

18. If an employee is applying for coverage for any court ordered dependent children, the employee must enter the court ordered dependent child(ren) custodial parent information in this section.

19. If the employee is selecting couple, family or parent plus coverage he/she must include all dependent information. Ensure that this information corresponds with the level of coverage selected on page one of the application.

20. Ensure that the employee enters his/her correct Social Security Number.

Sample Health Insurance Update Form



COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
OFFICE OF PUBLIC EMPLOYEE HEALTH INSURANCE

HEALTH INSURANCE UPDATE FORM

NOTE: *You CANNOT ADD or DROP dependents on this form*

RED SECTIONS MUST BE COMPLETED BY THE INSURANCE COORDINATOR

GENERAL INFORMATION (*REQUIRED*)

SOCIAL SECURITY NUMBER
NAME
COMPANY NUMBER
COMPANY NAME

DOES EMPLOYEE HAVE COMMONWEALTH CHOICE? YES NO

☐ **TERMINATION**

DATE EMPLOYMENT TERMINATES _____ DATE INSURANCE TERMINATES _____

☐ **REINSTATE**

☐ **TRANSFER** → *TO BE COMPLETED BY THE NEW COMPANY*
→ *CANNOT MAKE CHANGES TO CURRENT COVERAGE*

OLD COMPANY # _____ NEW COMPANY # _____ DATE EMPLOYMENT CHANGED _____

TERMINATION DATE OF INSURANCE FROM OLD COMPANY # _____ EFFECTIVE DATE OF INSURANCE AT NEW COMPANY # _____

CURRENT COVERAGE PLAN CHOICE _____ LEVEL S PP C F Waive

OPTION A B CROSS REFERENCE? Y

OTHER CHANGES

☐ NAME NEW _____
PREVIOUS _____

☐ NEW ADDRESS _____
COUNTY CODE _____

☐ SSN CORRECT _____ INCORRECT _____

☐ DATE OF BIRTH _____

EMPLOYEE SIGNATURE DATE COORDINATOR SIGNATURE DATE

WHITE - ENROLLMENT INFORMATION BRANCH YELLOW - EMPLOYER PINK - EMPLOYEE Revised 09.20.02

1 2 3 4 5 6 6 7 8 9

Completing the Health Insurance Update Form

1. The employee's name and Social Security Number must be provided for any action requested using this Form.

2. The Insurance Coordinator is required to complete the Company Number and the Company Name for any action reported on this Form.

3. Indicate whether or not the employee participates in the Commonwealth Choice program.

4. If the Health Insurance Update Form is being completed to report a termination, please check Termination and provide the Date Employment Terminates & the Date Insurance Terminates.

5. Reinstate
   - School Boards – any contracted employee who is terminated at the end of the prior school year and is reinstated at the beginning of the new school year should complete the Update Form and select Reinstate. He/she does not have to complete a new health insurance application.
   - If a termination has been submitted incorrectly, the Insurance Coordinator should use the Update Form to reinstate coverage.

6. If the Health Insurance Update Form is being completed to report a transfer, the new company's Insurance Coordinator must select Transfer and provide all requested information in this section.

7. If the Health Insurance Update form is being completed to report any other changes (i.e. name change, address change, Social Security Number correction or date of birth correction) check the appropriate box and complete the required information.

8. The employee must sign and date the Form, when applicable.

9. The Insurance Coordinator must sign and date the Form.

The Health Insurance Update Form is used to report:

Terminations/Reinstatements It is required that you submit the Update Form and indicate the termination date for each employee who actually terminates (not transfers) from your agency. Include the employment termination date and the insurance termination date. Also, use the form to reinstate contract employees and correct termination dates.

Agency Transfers An employee transferring from one company number to another must complete an Update Form. The insurance coordinator at the new agency must sign this form.

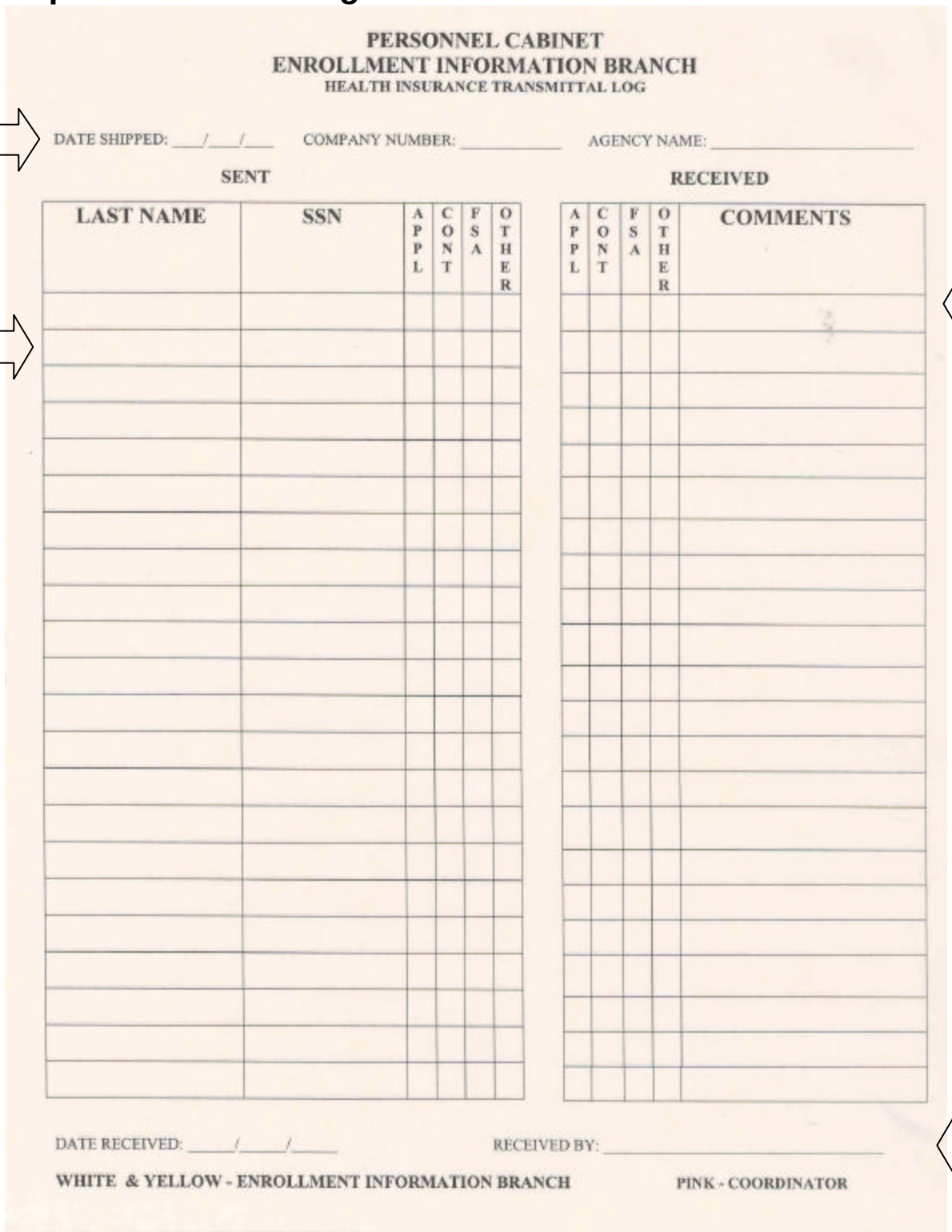
- An employee who transfers without a break in employment cannot change health insurance coverage or waiver elections.

- An employee who transfers is not allowed to change his/her coverage elections without a Qualifying Event unless the employee has been separated from his/her previous employer for at least sixty-three (63) calendar days.

Demographic Changes An employee who needs to correct his/her Social Security Number, name or date of birth should complete an Update Form for such changes. In addition, if the employee is reporting an address change, the new county name must be provided, if applicable.

Mail the top copy of the Update form to the OPEHI's Enrollment Information Branch. Keep the second copy in the employee's file. Give the third copy to the employee.

Sample Transmittal Log



PERSONNEL CABINET
ENROLLMENT INFORMATION BRANCH
HEALTH INSURANCE TRANSMITTAL LOG

1

DATE SHIPPED: ___/___/___ COMPANY NUMBER: _____ AGENCY NAME: _____

SENT						RECEIVED				
LAST NAME	SSN	APPL	CONT	FSA	OTHER	APPL	CONT	FSA	OTHER	COMMENTS

2

3

DATE RECEIVED: _____/_____/_____ RECEIVED BY: _____

4

WHITE & YELLOW - ENROLLMENT INFORMATION BRANCH PINK - COORDINATOR

Instructions for Completing the Transmittal Log

1. The Insurance Coordinator should complete the date the document(s) is mailed to the OPEHI. The Company Number and Agency Name must be included.

2. The Insurance Coordinator should indicate the document type; last name of the employee; and Social Security Number.

3. Upon receipt of the Transmittal Log and documents, OPEHI will indicate receipt, by individual, of the type of document received and any comments, if applicable.

4. The OPEHI will:

   - confirm the date of receipt;
   - indicate the documents received; and
   - return appropriate copy of the Transmittal Log to the Insurance Coordinator.